DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/08/12

PRINTED: 10/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445392	A. BUILDING _____ B. WING _____	10/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMSPLACE, LLC	1927 MEMORIAL BOULEVARD MURFREESBORO, TN 37129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual Recertification survey and investigation of complaint number TN-30557 was completed on October 24, 2012. No deficiencies were cited under 42 CFR PART 483.13, Requirements for Long Term Care for the complaint.	F 000	The Plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure staff asked permission or knocked on doors before entering resident rooms for two residents (#236, #242) of thirty- six sampled residents. The findings included: Resident #236 was admitted to the facility on October 16, 2012, with diagnoses including Cerebral Vascular Accident, Double Vision, Weakness, and Diabetes Mellitus. Medical record review of the Care Plan dated October 16, 2012, revealed identified problems areas of impaired vision, balance, and inability to ambulate. Medical record review of the Nurse's Note dated October 21, 2012, revealed alert and oriented.	F 241	F241 It is the policy and procedure of AdamsPlace HCC to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. RN apologized to residents #236 and #242 on 10/23/12 regarding failing to knock on pt room door or announcing self prior to entering pt's room. RN did knock on all other pt doors prior to entering throughout shift. RN was in-serviced by DON on 10/23/12 regarding patient privacy and dignity. DON and/or designee will complete QA monitor weekly for 3 weeks and as needed to ensure ongoing compliance.	11/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/8/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 Medical record review of a psychosocial assessment dated October 22, 2012, revealed the resident was cognitively intact. Observation on October 23, 2012, at 7:40 a.m., in the hallway, revealed Registered Nurse (RN) #1 entered the resident's room without knocking or obtaining permission to enter. Interview with RN #1 on October 23, 2012, at 9:45 a.m., in the 1200 hallway, confirmed the nurse failed to respect the resident's private space and failed to knock and request permission to enter the resident's room. Resident # 242 was admitted to the facility on October 18, 2012, with diagnoses including Knee Joint Replacement, Hypertension, and Peptic Ulcer Disease. Medical record review of the Care Plan dated October 18, 2012, revealed the resident had impaired functional mobility and was at risk for musculoskeletal discomfort. Medical record review of an Admission note dated October 19, 2012, revealed the resident was alert and oriented. Observation on October 23, 2012, at 7:48 a.m., in the resident's room, revealed Registered Nurse (RN) #1 entered the resident's room without knocking or obtaining permission to enter. Interview with RN #1 on October 23, 2012, at 9:45 a.m., in the 1200 hallway, confirmed the nurse failed to respect the resident's private	F 241		

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F 241	Continued From page 2 space and failed to knock and request permission to enter the resident's room.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide accurate information	F 278	F278 It is the policy and procedure of AdamsPlace HCC to complete a resident assessment that accurately reflects the resident's status. The MDS for resident #30 was unlocked, corrected and retransmitted to the state to reflect the accurate ADL coding for eating for the MDS dated 6/1/12. A clinical record review was completed on 10/25/12 to ensure that ADL coding of eating for any pt with a feeding tube was coded accurately. DON in-serviced the MDS coordinator regarding ADL coding for eating r/t feeding tube in use on 10/25/12. DON and/or designee will complete a QA monitor monthly for 3 months and as needed to ensure ongoing compliance.	11/5/12

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F 278	Continued From page 3 for the Minimum Data Set (MDS) assessment for one resident (#30) of thirty-seven residents reviewed. The findings included: Resident #30 was readmitted to the facility on May 25, 2012, with diagnoses including Gastrostomy, Dysphagia, Weight Loss; Malnutrition of Moderate Degree, and Aspiration Pneumonia. Medical record review of the Dietary Progress Note dated May 28, 2012, revealed the resident had a gastrostomy feeding tube, and received nothing by mouth (NPO). Medical record review of the admission MDS dated June 1, 2012, revealed the resident required extensive assist of one person for eating, and received 51% or more percent intake by artificial route (gastrostomy tube feeding). Medical record review of the 30 day MDS dated June 20, 2012, revealed the resident was dependent on staff for eating. Continued review revealed the resident received 51% or more percent intake by artificial route (gastrostomy feeding tube). Interview with the MDS Coordinator in the private dining room on October 24, 2012, at 9:55 a.m., confirmed the resident had received nothing by mouth, and nutritional support had been provided through the use of the feeding tube. Continued interview confirmed the resident's 5 day/Admission MDS dated June 1, 2012, was inaccurate.	F 278		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure soiled and biohazardous materials from the resident population. The findings included: Observation during initial tour on October 22, 2012, at 10:00 a.m., revealed a Certified Nurse Assistant (CNA) entered the soiled utility room and discarded soiled linen into containers. Continued observation revealed the door to the soiled utility room did not latch after the CNA entered the room to dispose of soiled linens. Observation on October 22, 2012, at 10:05 a.m., with Licensed Practical Nurse #2 (LPN), revealed LPN #2 attempted to restore the door to the locked position, but was unable to engage the latch. Interview with LPN #2 on October 22, 2012, at 10:05 a.m., confirmed the soiled utility room contained soiled linens and biohazard containers. Continued interview confirmed the door was not working properly, and should have latched and	F 323	F323 It is the policy and procedure of AdamsPlace HCC to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Maintenance staff was notified regarding soiled utility door not closing properly and the door was fixed on 10/22/12. Maintenance staff completed a check of all soiled utility doors to ensure proper working order on 10/22/12. Administrator in-serviced all partners regarding proper door latching procedures and timely notification to maintenance for any door not latching properly. Director of Plant Operations will complete a QA monitor weekly for 3 weeks and as needed to ensure ongoing compliance.	11/2/12

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F 323	Continued From page 5 locked automatically when closed.	F 323		
F 356 SS=D	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 356	F356 It is the policy and procedure of AdamsPlace HCC to post the nursing staffing data on a daily basis. The facility staffing data was updated immediately on 10/22/12 and was updated daily throughout remainder of survey. DON in-serviced the nursing secretary regarding timely posting of staffing data daily. DON and/or designee will complete a QA monitor monthly for 2 months and as needed to ensure ongoing compliance.	11/2/12

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F 356	Continued From page 6 failed to post nurse staffing data on a daily basis. The findings included: Observation on October 22, 2012, at 10:45 a.m., revealed the posted nurse staffing data was dated October 16, 2012. Observation and interview at this time with the Assistant Director of Nursing , in the skilled nurse's station, revealed the last posted nurse staffing data was on October 16, 2012, and confirmed the nurse staffing data was not posted for October 22, 2012.	F 356		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the exterior dumpster area in a sanitary manner. The findings included: Observation on October 22, 2012, at 10:00 a.m., with the Certified Dietary Manager (CDM) present, revealed two exterior dumpsters with several pieces of a broken watermelon shell and pink and green debris on the concrete surface in front of the dumpsters. Interview with the CDM on October 22, 2012, at 10:00 a.m., by the exterior dumpsters, confirmed the concrete in front of the dumpsters had pieces	F 372	F372 It is the policy and procedure of AdamsPlace HCC to dispose of garbage and refuse properly. CDM and Director of Plant Operations completed a thorough power washing of dumpsters and cleaned the surrounding area on 10/24/12. Administrator in-serviced all partners regarding proper procedures for disposing of refuse. CDM and/or Director of Plant Operations will complete a QA monitor weekly for 3 weeks and as needed to ensure ongoing compliance.	11/2/12

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F 372	Continued From page 7 of watermelon shell and pink and green debris present and should maintain a clean dumpster area. Observation on October 24, 2012, at 9:40 a.m., with the CDM present, revealed watermelon shell and pink and green debris present on the concrete in front of both exterior dumpsters. Further observation revealed paper plates, napkins, straws, and styrofoam cups on the concrete surface behind the dumpsters. Interview with the CDM on October 24, 2012, at 9:40 a.m., by the exterior dumpsters, confirmed the concrete surface in front of the dumpsters contained watermelon shell, pink and green debris, and paper debris behind the dumpsters.	F 372		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441 It is the policy and procedure of AdamsPlace HCC to ensure an infection control program is in place to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. DON in-serviced the RN and LPN on 10/23/12 and 10/24/12 respectively regarding proper infection control procedures including hand washing and glucometer use. All licensed staff will be in serviced regarding proper hand washing during the medication pass as well as proper infection control standards when completing blood glucose tests. DON and/or designee will complete a QA monitor monthly for 3 months and as needed to ensure ongoing compliance.	11/9/12

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F 441	Continued From page 8 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure staff washed hands after medication administration; and failed to maintain infection control during blood glucose monitoring for two residents (#236, #228) of four residents reviewed for blood glucose monitoring of thirty-six sampled residents. The findings included: Observation of a medication administration on October 24, 2012, at 8:35 a.m, revealed Licensed Practical Nurse #1 (LPN) administered medications to resident #224. Continued observation revealed after the LPN administered the medications, returned to the medication cart, retrieved a stethoscope and proceeded to	F 441		

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F 441	Continued From page 9 resident #234's room without washing the hands. Interview on October 24, 2012, at 9:00 a.m., with LPN #1, in the hallway, confirmed the nurse failed to wash the hands after administering the medications and prior to entering the resident's room Observation on October 23, 2012, at 7:40 a.m., on the 1200 hallway, revealed Registered Nurse (RN) #1 retrieved a blood glucose monitor from the medication cart, entered resident #236's room, placed the glucose monitor on the bedside table without a protective barrier. Continued observation at this time revealed RN #1 performed a blood glucose test for the resident, exited the resident's room, and placed the blood glucose monitor on the medication cart. Observation on October 23, 2012, at 7:44 a.m., on the 1200 hallway, revealed Registered Nurse (RN) #1 retrieved a blood glucose monitor from a drawer of the medication cart and placed the glucometer on top of the cart. Continued observation at this time revealed RN #1 entered resident #228's room, placed the glucose monitor on the resident's food tray without a protective barrier, performed a blood glucose test for the resident, exited the room, and placed the blood glucose monitor on the medication cart. Review of facility policy, Maintaining Glucometer, revealed "...infection control standards will be maintained..." Interview with RN #1 on October 23, 2012, at 7:45 a.m., on the 1200 hallway, confirmed a protective barrier was to be placed under the	F 441		

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F 441	Continued From page 10 blood glucometer. Interview with the Assistant Director of Nursing (ADON) on October 23, 2012, at 9:30 a.m., in the ADON Office, revealed the staff complete a competency checklist and are instructed to use a protective barrier when performing blood glucose monitoring to prevent cross contamination. Continued interview confirmed the nurse failed to follow infection control standards when completing blood glucose tests.	F 441		